measurement of the erythrocyte sedimentation rate will be abandoned, but its limitations should be recognised.

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I don't want you to see a psychiatrist

Non-psychiatrists provide most mental health care

Twenty five years ago Kessel asked who ought to receive psychiatric care in Britain.[1] He argued that psychiatrists should welcome increasing public demand for their services and that general practitioners should be encouraged to refer patients freely to psychiatrists "when they want advice." As we now know most acutely ill patients with psychotic disorders see a psychiatrist. The rest of those with psychiatric problems—about 95% of the total[2]—are treated by general practitioners, usually alone but sometimes together with various non-medical providers of mental health care. General practitioners are turning increasingly to nurses, social workers, clinical psychologists, and counsellors rather than to psychiatrists for help for their patients with mental health problems.

General practitioners are the largest group referring patients to community psychiatric nurses.[3] Community psychiatric nurses working in health centres are most commonly asked to help with patients with mood disorders, but they also treat patients with neurotic and psychotic disorders.[4] Two randomised controlled trials have shown clinical and economic benefits from nurses treating patients with neurotic disorders in the community. Firstly, community psychiatric nursing was compared with routine outpatient psychiatric follow up over 18 months. Community psychiatric nursing resulted in an appreciable reduction in outpatients' contacts with psychiatrists and other staff, more discharges, and a small increase in contact with general practitioners for prescribing.[5,6] Secondly, neurotic patients (mainly those with phobic and obsessive-compulsive disorders) had a better outcome one year after receiving behavioural psychotherapy from a nurse therapist than after routine treatment from a general practitioner.[7,8] Practice nurses already provide much emotional support to patients with physical and psychiatric illness, though this is largely unrecorded. In addition, health visitors are important in identifying and treating emotional problems in women who have recently given birth.[9]

Two randomised controlled trials have shown the effectiveness of social work for depressed patients. In one study women suffering from acute or acute on chronic depression were referred to a social worker attached to a general practice or for routine treatment by their general practitioners. Women with acute on chronic depression and large marital difficulties benefited from treatment by social workers.[10,11] In the other study depressed patients were allocated to individual cognitive therapy, group cognitive therapy, or a waiting list control group.[12] Those who had cognitive therapy from a social worker did significantly better up to one year than those on the waiting list, but there was no significant difference between patients treated with group or individual cognitive therapy.

General practitioners refer to clinical psychologists patients with difficulties ranging from anxiety, phobia, depression, and psychosomatic conditions to habit disorders, behavioural, personality, interpersonal, social, marital, sexual, educational, and occupational problems, and cognitive impairment. Patients show high satisfaction with behavioural treatment,[13] and they have a third to a half fewer consultations for advice or prescriptions for psychotropic drugs in the year after psychological intervention.[14,15] Such benefits have been confirmed up to one year in a randomised controlled clinical and economic evaluation of a behaviourally oriented clinical psychology service in a health centre.[16] Contact with a psychologist may have effects on referred patients and their families over the longer term, with decreases at three years in the number of prescriptions for psychotropic drugs for their children.[17] Advantages have also been shown for specific psychological treatments in patients with depression and anxiety. Two controlled clinical trials have produced favourable early results for psychologists using cognitive therapy combined with antidepressants in treating depressive disorders.[18,19] Group psychological treatment for anxiety has been compared with individual treatment: individual treatment was more effective in reducing anxiety and service demands were considerably reduced by group treatment.[20]

A growing number of counsellors are being recruited into primary care. Individual, family, group, and marital counselling are used, and the counsellor's main aim is to offer the patient support and insight. Patients are also given the chance to learn new skills, such as relaxation, and vocational and educational guidance may be given. Several clinical accounts show the impact of counselling in general practice—for example, on subjective feelings of patients and general practitioners and on reductions in the number of consultations and prescriptions for psychotropic drugs.[21-24] People with marital difficulties are more likely to contact their general practitioners for help than any other social service, and several attachments of marriage guidance counsellors to general practice have been set up to encourage doctors to refer patients directly.[25] These attachments seem to work well, but the experience is limited to self selected and atypical practices.

We have done a meta-analysis[26] on 11 British studies[8,10,12,13,16,19,23,27-30] of specialist mental health treatment in general practice. In each study the outcome of treatment by a specialist mental health professional located in general practice was compared quantitatively with the outcome of the usual

treatment by general practitioners. The main finding was that treatment by specialist mental health professionals was about 10% more successful than that usually given by general practitioners. Counselling (including social work), behaviour therapy, and general psychiatry proved to be similar in their overall effect. The influence of counselling seemed to be greatest on social functioning, whereas behaviour therapy seemed mainly to reduce contacts with the extramural psychiatric services.

General practitioners are currently collaborating with paramedical workers and statutory and voluntary agencies to provide the overwhelming bulk of psychiatric care in Britain. At the same time general practitioners in many parts of Britain have no alternative to referring patients to a psychiatrist. The evidence supports the effectiveness of the different therapeutic approaches, though none of the studies is entirely satisfactory. Moreover, most of the advantages of intervention by a non-psychiatrist have been shown in patients with non-psychotic disorders. The role and skills of psychiatrists in reinforcing the effectiveness of the general practitioner and the primary care team remains an unresolved issue.

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Orthotic services: a need for change

Separate the fees for fitting and manufacturing

The service to provide external splints and appliances—now called orthoses—has been virtually privatised since the beginning of the NHS. It costs about £38m yearly. About 130 different firms tender prices for a year at a time for supplying some 1400 different standard orthoses. The firm chosen to supply a hospital will send their fitter (or orthotist) to attend clinics. The patient is measured or a cast made, and the appliance is eventually fitted. The contract states that this must be done within six weeks.

There have been complaints about the orthotic (and prosthetic) service for years, and several reports have made essentially similar recommendations.[1-4] The consensus is that patients are not getting the service or the technology that is available. The reports have recommended that orthotic and prosthetic services should be less separated, that the NHS hospital workshops (currently constituting less than 3% of the service) should be fostered, and that the contracting system should be changed.

One problem is the way that orthotists' services are organised. Several district health authorities have examined their orthotic services, and Southampton Health Authority has, for example, concluded that it could save up to £68 000 a year by employing its own orthotist manager.[5] Bristol and Weston Health Authority has been doing this for years, and Bloomsbury Health Authority would if it could recruit orthotists. The Whitley scales of pay for NHS orthotists (on the rates of medical physics technicians) are, however, some £2000—4000 a year less than the salaries available in the private sector—not counting the car and other perks commonly available. They are thus insufficient to attract (or retain) orthotists. Health authorities seeking to employ their own orthotists have to resort to devious arrangements to find salaries approaching those in the commercial sector.

The contract price, which is now agreed by district health authorities, is for both fitting and supplying orthoses. The price is the same, for example, for a calliper for an easily fitted, normally shaped leg as for a calliper for a difficult leg requiring multiple fittings and much skill and attention from the orthotist. Under the present system these cases present a difficulty for commercial orthotists, who have a professional duty to the patient and a commercial responsibility to their employer. Too often the patient is left with an ill fitting, ugly, and non-effective appliance.

If the charges for the two distinct parts of the service—that is, fitting (including casting, measuring, and so on) and manufacturing—were to be separated orthotists could be paid directly for their principal duties: fitting patients. If their employment was unconnected with the commercial aspects of manufacture they would be better able to select impartially the best buy for the patient (and the economy). Hospital